## Executive Summary

**The proper role of the State of Texas in the provision of inpatient and outpatient hospital services relating to tuberculosis and a variety of other clinical conditions has become an increasingly significant issue. This is a result of the two Texas Department of Health hospitals being at risk of losing important accreditation due to aging and deteriorating buildings and the recurring lack of adequate operating funds due to the continued decline in the percent of paying patients.**

**The body of this study investigates the breadth of services provided at the TDH hospitals. Because of the statewide and international implications of tuberculosis; because it is for this disease that these hospitals were built and have been maintained; and because most of the hospitals' aggregated expenditures are for TB diagnosis and care, the Executive Summary focuses attention to TB services. It is important to remember, however, that these hospitals serve the State in many ways, all of which are important in consideration of options for their continuation.**

**Tuberculosis is a contagious and infectious disease which is present throughout most of the world and is now the world's number one communicable disease killer. It is transmitted when a person inhales airborne infectious droplet nuclei produced by a contagious individual who talks, sneezes, and/or coughs. Risk factors for acquiring TB include being in a community where TB is prevalent, homelessness, substance abuse, incarceration, and certain medical conditions such as human immunodeficiency virus (HIV) infection and diabetes. From 1970 through 1980 TB cases reported in Texas decreased an average of 3% per year. However, TB cases began to increase in the mid-1980's continuing until 1994, when the number of cases reached a twenty-year high of 2, 542 and a case rate of 12.7 per 100,000. Since 1994, though, control of TB appears to have been restored, and a declining number of cases is being seen.**

**Pursuant to a TDH request to the 75th Legislature for funding substantial renovations to its two hospitals in order to sustain Joint Commission for Accreditation of Healthcare Organizations (JCAHO) accreditation, the Texas Legislature required TDH to develop a long-range plan for addressing inpatient and outpatient needs currently provided by the TDH hospitals. TDH currently operates one hospital in San Antonio, the Texas Center for Infectious Disease (TCID) and one hospital in Harlingen, the South Texas Hospital (STH). TCID currently provides inpatient and outpatient TB services as well as some other non-TB services such as women's health laboratory services. STH currently provides inpatient and outpatient services for not only TB services but also selected non-TB medical and surgical services.**

**To augment the provision of TB inpatient hospital care for early diagnosis and emergency care provided by local public and private hospitals throughout the State, the State of Texas manages three hospitals with units devoted to TB services. Two are managed by TDH and one is managed by University of Texas Health Center-Tyler (UTHC-Tyler). Since most of the TDH hospitals' patients are medically indigent, it is probable that demand will continue for**

**the TB patient population which has traditionally been served by the TDH hospitals and the UTHC-Tyler patient care unit.**

**Because of the heavy medically indigent case load, the two TDH hospitals are able to qualify for millions of Medicaid disproportionate share hospital (DISPRO) dollars ($12.4 million in federal dollars for 1998). From 1998 through 2002, it is estimated that the TDH hospitals will generate over $85 million of DISPRO payments, of which approximately $54 million are federal funds or approximately 63% of the total.**

**There are complexities which impact estimating total demand for State managed inpatient beds for confirmed TB cases. Data indicates that public and private hospitals in most areas of the State are providing inpatient TB hospital services to persons infected with TB. However, for many medically indigent persons who require long lengths of stay, the State managed hospitals are the safety net providers. For example, of the 1,992 total number of TB cases in Texas in 1997, 1,054 cases were hospitalized at some point in the course of their TB treatment, with 270 of these admissions to TDH hospitals, which maintained a combined average daily census of 87 TB patients. Estimating inpatient bed needs for the future assumes that the existing public and private hospital support for inpatient TB care will continue and that the State will continue to address the population which during the past five to ten years has relied upon the State managed TB hospitals. It is noted that the ability of public hospitals to continue to provide inpatient services to persons who are indigent could be adversely affected during the next decade if DISPRO funding is materially reduced. Even though most recent trends indicate TB cases are declining, which should indicate fewer admissions, the mix of increasing multiple-drug resistant cases is expected to increase the overall average hospital length of stay for those that are admitted.**

**To create a long-range plan, options were developed and examined against public health and clinical benefit, and financial and public expectation impact criteria.**

**Option A provides that each of the TDH hospitals be maintained and renovated sufficiently to sustain JCAHO accreditation with some modification in focus and that management be retained by TDH or assigned to UTHC-Tyler.**

- **Services at the TCID should focus on outpatient and subacute inpatient long term care for persons with TB. Acute care services such as surgery, intensive care, sophisticated radiology, and emergency services currently are coordinated with other hospitals such as the UTHC-Tyler, and Southeast Baptist Hospital in San Antonio.**

**Options considered to continue the level of service currently provided at TCID include:**

- **construction of a new subacute long term care hospital with estimated construction cost of $21 million;**
- **renovation of existing buildings pursuant to the "Facilities Cost Analysis" prepared by Kennedy Associates Incorporated with estimated cost of $25 million (Appendix A);**
- **construction of a new medical surgical hospital with estimated cost of $26 million; or**
- **consolidation and renovation of selected existing buildings on the campus with an estimated cost of $10.5 million.**

**Services at STH would focus on inpatient subacute long term care for persons with TB and on inpatient and outpatient medical and surgical services. Acute care services such as surgery, intensive care, sophisticated radiology and emergency services currently are coordinated with other hospitals such as UTHC-Tyler, UT Medical Branch-Galveston, Valley Baptist Medical Center-Harlingen, and Brownsville Medical Center. Options considered for the STH included:**

- **construction of a new medical surgical hospital with an estimated cost of $26 million;**
- **construction of a new subacute long term care hospital with an estimated cost of $21 million; or**
- **renovation of existing buildings pursuant to the "Facilities Cost Analysis" report with an estimated cost of $18.5 million.**

**If management is assigned to UTHC-Tyler for both TCID and STH, it is anticipated that UTHC-Tyler will coordinate the provision of selected medical, surgical and support services currently provided at STH with other UT Health System providers to sustain the services.**

**Option B considered renovating TCID and STH but eliminating the medical and surgical services currently provided by STH. This option will reduce the cost for renovation since only the TB portion of the facility will be renovated and the operating costs will be reduced since the majority of the admissions are currently for medical and surgical services. STH currently provides medical and surgical services to a number of medically indigent persons in the Lower Rio Grande Valley who need both inpatient and outpatient hospital services, but their needs are not for emergency conditions which would provide them access to other hospitals in the Valley.**

**The Lower Rio Grande Valley is currently the largest population center in the State without a locally funded hospital district to fill the gap for medical and surgical non-emergency patient care services. Therefore, the most significant impact of this option is that medical and surgical non-emergency services will be reduced to the medically indigent population in the Lower Rio Grande Valley unless suitable providers are available to meet the needs.**

**Options C, D, and E considered combining the services of the two TDH hospitals into one of the existing locations, making necessary renovations to the consolidated facility, and maintaining state management of the combined operation by either TDH or UTHC-Tyler. If reliable patient transportation can be provided over the long distances required, either STH or TCID could manage the capacity for their current combined inpatient TB services. Additionally, TCID does not provide surgical services and the Lower Rio Grande Valley currently does not have a locally funded hospital district to fill the gap for medical and surgical non-emergency patient care services. Consolidation problems also include the loss of DISPRO funding for the State's general fund, difficulty in complying with the Immigration and Naturalization Service (INS) requirements which restricts non-citizen transportation to interior locations in the State, and access to continuity of care for more intensive or specialized treatment. Any of these options will have an impact on TDMHMR.**

**Despite the noted impediments to combining services in either TCID or STH, this report includes three scenarios for consolidation.**

- **Option C: Retains STH and closes TCID with STH continuing to provide TB, medical, surgical and support services.**
- **Option D: Retains STH and closes TCID with STH continuing to provide only TB services.**
- **Option E: Retains TCID to provide only inpatient and outpatient TB services and closes STH.**

**Option F considered outsourcing inpatient care operations of either or both of the TDH hospitals. Because of the substantial federal funds projected to continue to be available to the State over the next five years from the DISPRO payments, this option is problematic for the State at this time. The State would forego an estimated $54 million in federal payments to the State's general fund if both hospitals were closed. Additionally, unit cost factors of area hospitals and the difficulty in constructing a special entitlement program for persons medically indigent now being served indicate outsourcing on a fee-for-service basis is not cost effective from a state finance perspective.**

**In 1994, the last year that such data are available from TDH, 246 hospitals saw at least one patient with TB. However, only 28 of these hospitals treated 20 or more patients. During this study, the leadership was interviewed at many of the hospitals with larger numbers of TB patients. No hospital was ready or able to accept the TB cases currently treated by TDH hospitals. These hospitals are high volume, high census inpatient facilities which focus on provision of acute care services. None reported unoccupied or underutilized inpatient units which could be renovated to provide services to inpatients with TB.**

**Hospital leaders in the Lower Rio Grande Valley, while sympathetic to the patient needs and supportive of the medicine, surgery, clinical support, and TB services at South Texas Hospital, stated during interviews that uncompensated care loads are managed in each community hospital in individualized ways. These ways of managing care do not consider options for further uncompensated services from non-specific numbers of persons residing in the four-county area of the Lower Rio Grande Valley. The state match of general revenue funds for Title V currently funded to STH would need to be reallocated to another provider or facilities willing to provide cost-based services or limit access to a capped funding stream. The lack of an eligibility entitlement program for STH patients is a major budgetary and administrative concern.**

**Additional government initiatives are presumed to impact the implementation of this plan and warrant on-going monitoring. Some of these initiatives include the University of Texas Board of Regents' expected decision during the fall of 1998 regarding the creation of a Regional Academic Health Center in the Lower Rio Grande Valley; the Brooks Air Force Base/San Antonio study efforts for using Brooks Air Force Base for various alternatives; the binational initiatives on-going between the U.S. and Mexican federal governments to address the control**

**of TB; TDMHMR facility evaluations; and the effects of implementation of the Immigration Reform Act.**

**This study leads to a strong conclusion that the State of Texas does not have an easy course to pursue. TB is the world's number one communicable disease killer and will remain a major, costly health care challenge for the foreseeable future. For Texas the problem is accentuated by our proximity to Mexico with its extremely high rate of TB infection and multiple drug resistant TB. The necessary steps and concomitant outlay of funding, to assure timely, clinically appropriate intervention and treatment of TB must be forthcoming in the short term.**